(4) STANDARD POLICY. The requirements of s. Ins 6.76 shall apply to any multiple peril insurance contract which includes insurance against loss or damage by fire.

History: Cr. Register, July, 1958, No. 31, eff. 8-1-58; am. (3) (a), Register, November, 1960, No. 59, eff. 12-1-60; emerg. am. (1), (2), (3) (a) and (4), eff. 6-22-76; am. (1), (2), (3) (a) and (4), Register, September, 1976, No. 249, eff. 10-1-76; am. (1) (a) and (b), (2) and (4), Register, March, 1979, No. 279, eff. 4-1-79.

Ins 3.12 Filing procedures for disability insurance forms. (1) PURPOSE. This rule establishes a procedure under which disability insurance policy forms must be filed before issuance or delivery in this state. This rule interprets, including but not limited to, the following Wisconsin Statutes: 601.01 (3), 601.41 and 631.20.

(2) SCOPE. This rule shall apply to all disability insurance forms subject to s. 631.01 (1), Stats., except as exempted under s. 631.01 (2), (4) and (5), Stats.

(3) FILING PROCEDURE. All such forms, including applications which are made a part of the contract, certificates, riders, endorsements and amendments, must be filed as follows:

(a) One copy of all such forms (2 copies should be submitted if the insurer desires one copy stamped as approved and returned) shall be submitted with, in the case of a policy form, a copy of the application applying thereto, if such application is to be made a part of the contract. If such application form is already on file and has been previously approved, the form number and date of approval may be submitted rather than the form.

(b) If the nature of the information to be inserted in any blank space of any such form cannot be determined from the wording of the form, such blank space shall be filled in with hypothetical data to the extent needed to indicate the purpose and use of the form. As an alternative, such purpose and use may be explained in the filing letter submitted with the form.

(c) The filing letter shall be in duplicate and shall contain the following information:

1. The identifying form number and title, if any, of the form,

2. A general description of the form,

3. In case of an application, certificate, rider, endorsement or an amendment form, the form numbers, identifying symbols or types of policies with which such forms will be used, and

4. The form number and date of office approval of any form superseded by the filing.

(d) A certificate of compliance in a form substantially similar to that set forth in Exhibit A of this rule shall be submitted.

EXHIBIT A

(Each policy form filing under Ins 3.12 shall be accompanied by the following "Certification of Compliance" in substantially this form.)

CERTIFICATION OF COMPLIANCE

I, _____, an officer of
(name)
_____, hereby certify that I have authority
(company name)
to bind and obligate the company by filing of this (these) form(s). I further certify that, to the best of my information, knowledge and belief,

(a) The accompanying form(s) as identified by the listing attached hereto does (do) comply with all applicable provisions of the Wisconsin Statutes and with all applicable rules of the Commissioner of Insurance; and

(b) (1) The form(s) does (do) not contain any inconsistent, ambiguous, or misleading clauses;

(2) The form(s) does (do) not contain specifications or conditions that unreasonably or deceptively limit the risk purported to be assumed in the general coverage of the policy form(s);

(3) The only variations from a form currently on file with the Commissioner of Insurance and the only unconventional policy provisions are clearly marked or otherwise indicated on the respective pages _____ of the attached form(s) or in addendum attached thereto; and

(4) The attached form(s) is (are) in final printed format and is (are) exactly as will be offered for issuance or delivery in the State of Wisconsin after approval by the Commissioner of Insurance, except for hypothetical data and other appropriate variable material.

_____
(signature)

_____
(title)

_____
(date)

Individual responsible for this filing:

Name: _____ Title: _____

Address: _____

Phone Number: _____ Date _____

History: Cr. Register, January, 1980, No. 289, eff. 2-1-80.

Ins 3.13 Individual accident and sickness insurance. (1) PURPOSE. This rule implements and interprets applicable statutes for the purpose of establishing procedures and requirements to expedite the review and approval of individual accident and sickness policies permitted by s. Ins 6.75 (1) (c) or (2) (c), and franchise type accident and sickness policies permitted by s. 600.03 (34m) (d), Stats. The requirements in subs. (2), (3), (4), (5), and (6) are to be followed in substance, and wording other than that described may be used provided it is not less favorable to the insured or beneficiary.

You may disenroll from the plan at any time for any reason. However, it may take up to 60 days to return you to the regular Medicare program. Your disenrollment will become effective on the day you return to regular Medicare. You will be notified by the plan of the date on which your disenrollment becomes effective. The plan will return any unused premium to you on a pro rata basis.

2. The Medicare replacement policy may require requests for disenrollment to be in writing. Enrollees may not be required to give their reasons for disenrolling, or to consult with an agent or other representative of the insurer before disenrolling.

(k) A policy which contains any provision under which the claimant may elect one benefit in lieu of another shall not limit to a specified period the time within which election may be made.

(3) RIDERS AND ENDORSEMENTS. (a) A rider is an instrument signed by one or more officers of the insurer issuing the same to be attached to and form a part of a policy. All riders shall comply with the requirements of s. 204.31 (2) (a) 4, 1973 Stats.

(b) If the rider reduces or eliminates coverage of the policy, signed acceptance of the rider by the insured is necessary. However, signed acceptance of the rider is not necessary when the rider is attached at the time of the original issuance of the policy if notice of the attachment of the rider is affixed on the face and filing back, if any, in contrasting color, in not less that 12-point type. Such notice shall be worded in one of the following ways:

"Notice! See Elimination Rider Attached"

"Notice! See Exclusion Rider Attached"

"Notice! See Exception Rider Attached"

"Notice! See Limitation Rider Attached"

"Notice! See Reduction Rider Attached"

A company may submit, subject to approval by the commissioner, other wording which it believes is equally clear or more definite as to subject matter.

(c) An endorsement differs from a rider only in that it is applied to a policy by means of printing or stamping on the body of the policy. All endorsements shall comply with the requirements of s. 204.31 (2) (a) 4, 1973 Stats.

(d) If the endorsement reduces or eliminates coverage of the policy, signed acceptance of the endorsement by the insured is necessary. However, signed acceptance of the endorsement is not necessary when the endorsement is affixed at the time of the original issuance of the policy if notice of the endorsement is affixed on the face and filing back, if any, in contrasting color, in not less than 12-point type. Such notice shall be worded in one of the following ways:

"Notice! See Elimination Endorsement Included Herein"

"Notice! See Exclusion Endorsement Included Herein"

"Notice! See Exception Endorsement Included Herein"

"Notice! See Limitation Endorsement Included Herein"

"Notice! See Reduction Endorsement Included Herein"

A company may submit, subject to approval by the commissioner, other wording which it believes is equally clear or more definite as to subject matter.

(4) APPLICATIONS. (a) Application forms shall meet the requirements of s. Ins 3.28 (3).

(b) It shall not be necessary for the applicant to sign a proxy provision as a condition for obtaining insurance. The applicant's signature to the application must be separate and apart from any signature to a proxy provision.

(c) The application form, or the copy of it, attached to a policy shall be plainly printed or reproduced in light-faced type of a style in general use, the size of which shall be uniform and not less than 10-point.

(6) RATE FILINGS. (a) The following must be accompanied by a rate schedule:

1. Policy forms.

2. Rider or endorsement forms which affect the premium rate.

(b) The rate schedule shall bear the insurer's name and shall contain or be accompanied by the following information:

1. The form number or identification symbol of each policy, rider or endorsement to which the rates apply.

2. A schedule of rates including policy fees or rate changes at renewal, if any, variations, if any, based upon age, sex, occupation, or other classification.

3. An indication of the anticipated loss ratio on an earned-incurred basis.

4. Any revision of a rate filing shall be accompanied by a statement of the experience on the form and the anticipated loss ratio on an earned-incurred basis under the revised rate filing.

5. Subdivisions 3 and 4 shall not apply to non-cancellable policies or riders or non-cancellable and guaranteed renewable policies or riders or guaranteed renewable policies or riders.

History: Cr. Register, March, 1958, No. 27; subsections (1), (5), (6) eff. 4-1-58; subsections (2), (3), (4) eff. 5-15-58; am. (2) (c) and cr. (4) (c), Register, March, 1959, No. 39, eff. 4-1-59; am. (2) (e), (6) (b) 3 and 4, Register, November, 1959, No. 47, eff. 12-1-59; am. and renum. (2) (c), (d), (e), (f), (g) and (h); am. (3) and (6) (b) 5, Register, June, 1960, No. 54, eff. 7-1-60; am. (2) (e) 4, Register, November, 1960, No. 59, eff. 12-1-60; r. (2) (j), Register, April, 1963, No. 88, eff. 5-1-63; cr. (2) (j), Register, March, 1964, No. 99, eff. 4-1-64; am. (2) (e) 2 and 4, Register, April, 1964, No. 100, eff. 5-1-64; am. (2) (j) 2.; am. NOTE in (2) (j) 3; Register, March, 1969, No. 159; eff. 4-1-69; cr. (2) (k), Register, June, 1971, No. 186, eff. 7-1-71; am. (4) (a), Register, February, 1974, No. 218, eff. 3-1-74; emerg. am. (1), (2) (e) 7, (2) (j), (3) (a) and (c), eff. 6-22-76; am. (1), (2) (e) 7, (2) (j), (3) (a) and (c), Register, September, 1976, No. 249, eff. 10-1-76; am. (1) and (2) (e) 7, Register, March, 1979, No. 279, eff. 4-1-79; r. (5), Register, January, 1980, No. 289, eff. 2-1-80; am. (2) (j) 3., Register, June, 1982, No. 318, eff. 7-1-82; emerg. am. (2) (j) and cr. (2) (jm), eff. 11-19-85; am. (2) (j) (intro.) and cr. (2) (jm), Register, March, 1986, No. 363, eff. 4-1-86.

Ins 3.14 Group accident and sickness insurance. (1) PURPOSE. This rule implements and interprets applicable statutes for the purpose of establishing procedures and requirements to expedite the review and approval of group accident and sickness policies permitted by s. 600.03 (34m) (b), Stats.

(3) RATE FILINGS. Schedules of premium rates shall be filed in accordance with the requirements of ch. 601 and s. 631.20, Stats. The schedules of premium rates shall bear the insurer's name and shall identify the coverages to which such rates are applicable.

(4) CERTIFICATES. (a) Each certificate issued to an employe or member of an insured group in connection with a group insurance policy shall include a statement in summary form of the provisions of the group policy relative to:

1. The essential features of the insurance coverage,

2. To whom benefits are payable,

3. Notice or proof of loss,

4. The time for paying benefits, and

5. The time within which suit may be brought.

(5) COVERAGE REQUIREMENTS. (a) Policies issued in accordance with s. 600.03 (34m) (b), Stats., shall offer to insure all eligible members of the group or association except any as to whom evidence of insurability is not satisfactory to the insurer. Cancellation of coverage of individual members of the group or association who have not withdrawn participation nor received maximum benefits is not permitted, except that the

insurer may terminate or refuse renewal of an individual member who attains a specified age, retires or who ceases to actively engage in the duties of his profession or occupation on a full-time basis or ceases to be an active member of the association or labor union or an employe of the employer, or otherwise ceases to be an eligible member.

(b) Surgical benefit provisions or schedules shall provide that the benefit for any covered surgical procedure not specifically listed in the schedule and not excluded by the provisions of the policy shall be determined by the company on a basis consistent with the benefit provided for a comparable listed procedure.

(c) A policy which contains any provision under which the claimant may elect one benefit in lieu of another shall not limit to a specified period the time within which election may be made.

(6) ELIGIBLE GROUPS. In accordance with s. 600.03 (34m) (b), Stats.:

(a) the members of the board of directors of a corporation are eligible to be covered under a group accident and sickness policy issued to such corporation,

(b) the individual members of member organizations of an association, as defined in s. 600.03 (34m) (b), Stats., are eligible to be covered under a group accident and sickness policy issued to such association insuring employes of such association and employes of member organizations of such association, and

(c) the individuals supplying raw materials to a single processing plant and the employes of such processing plant are eligible to be covered under a group accident and sickness policy issued to such processing plant.

History: Cr. Register, March, 1958, No. 27; subsections (1), (2), (3), eff. 4-1-58; subsections (4), (5), eff. 5-1-58; renum. (5) to be (5) (a); cr. (5) (b), Register, November, 1959, No. 47, eff. 12-1-59; am. (1) (3), (5) (a) and cr. (6), Register, October, 1961, No. 70, eff. 11-1-61; am. (6), Register, February, 1962, No. 74, eff. 3-1-62; cr. (5) (c), Register, June, 1971, No. 186, eff. 7-1-71; emerg. am. (1), (3), (5) (a), (6) (intro.) and (6) (b), eff. 6-22-76; am. (1), (3), (5) (a), (6) (intro.) and (6) (b), Register, September, 1976, No. 249, eff. 10-1-76; r. (2), Register, January, 1980, No. 289, eff. 2-1-80.

Ins 3.15 Blanket accident and sickness insurance. (1) PURPOSE. This rule implements and interprets applicable statutes for the purpose of establishing procedures and requirements to expedite the review and approval of blanket accident and sickness policies permitted by s. 600.03 (34m) (c), Stats.

(3) RATE FILINGS. Schedules of premium rates shall be filed in accordance with the requirements of ch. 601 and s. 631.20, Stats. The schedules of premium rates shall bear the insurer's name and shall identify the coverages to which such rates are applicable.

(4) ELIGIBLE RISKS. (a) In accordance with the provisions of s. 600.03 (34m) (c), Stats., the following are eligible for blanket accident and health insurance: 1. Volunteer fire departments, 2. National guard units, 3. Newspaper delivery boys, 4. Dependents of students, 5. Volunteer civil defense organizations, 6. Volunteer auxiliary police organizations, 7. Law enforcement agencies, 8. Cooperatives organized under ch. 185, Stats., on a membership basis without capital stock, 9. Registered guests in a motel, hotel, or resort, 10. Members or members and advisors of fraternal organizations including women's auxiliaries of such organiza-

tions and fraternal youth organizations, 11. Associations of sports officials, 12. Purchasers of protective athletic equipment, 13. Migrant workers, 14.Participants in racing meets, 15. Patrons or guests of a recreational facility or resort.

(b) A company may submit any other risk or class of risks, subject to approval by the commissioner, which it believes is properly eligible for blanket accident and health insurance.

(5) COVERAGE REQUIREMENTS. (a) Surgical benefit provisions or schedules shall provide that the benefit for any covered surgical procedure not specifically listed in the schedule and not excluded by the provisions of the policy shall be determined by the company on a basis consistent with the benefit provided for a comparable listed procedure.

(b) A policy which contains any provision under which the claimant may elect one benefit in lieu of another shall not limit to a specified period the time within which election may be made.

History: Cr. Register, March, 1958, no. 27, eff. 4-1-58; am. (4) (a), cr. (5), Register, November, 1959, No. 47, eff. 12-1-59; am. (1), (3) and (4) (a), Register, October, 1961, No. 70, eff. 11-1-61; am. (4) (a), Register, April, 1963, No. 88, eff. 5-1-63; am. (4) (a), Register, June, 1963, No. 90, eff. 7-1-63; am. (4) (a), Register, October, 1963, No. 94, eff. 11-1-63; am. (4) (a), Register, August, 1964, No. 104, eff. 9-1-64; am. (4) (a), Register, August, 1968, No. 152, eff. 9-1-68; am. (4) (a), Register, March, 1969, No. 159, eff. 4-1-69; am. (4) (a), Register, August, 1970, No. 176, eff. 9-1-70; am. (4) (a), renum. (5) to be (5) (a), and cr. (b), Register, June, 1971, No. 186, eff. 7-1-71; emerg. am. (1), (3) and (4) (a), eff. 6-22-76; am. (1), (3) and (4) (a), Register, September, 1976, No. 249, eff. 10-1-76; r. (2), Register, January, 1980, No. 289, eff. 2-1-80.

Ins 3.17 Reserves for accident and sickness policies. (1) PURPOSE. This rule establishes minimum standards for insurance company active life reserves and claim liability reserves as authorized by ch. 623, Stats., and for fraternal benefit society reserves as authorized by s. 623.15, Stats.

(2) SCOPE. This rule shall apply to the kinds of insurance authorized by s. Ins 6.75 (1) (c) or (2) (c), and shall also apply to fraternal benefit contracts subject to s. 632.94, Stats.

(3) ACTIVE LIFE RESERVES, INDIVIDUAL AND FRANCHISE POLICIES. Active life reserves are required for all in force policies issued subject to s. Ins 6.75 (1) (c) or (2) (c), ss. 600.03 (34m) (d), and 632.94, Stats.

(a) For purposes of this rule, individual policies will be classified as follows:

1. Policies which are non-cancellable or non-cancellable and guaranteed renewable for life or to a specified age.

2. Policies which are guaranteed renewable for life or to a specified age.

3. Policies, other than those in subpar. 5 of this paragraph, in which the insurer has reserved the right to cancel or refuse renewal for one or more reasons, but has agreed implicitly or explicitly that, prior to a specified time or age, it will not cancel or decline renewal solely because of deterioration of health after issue.

4. Franchise policies, as defined in s. 600.03 (34m) (d), Stats., issued under or subject to an agreement that, except for stated reasons, the insurer will not cancel or refuse to renew the coverage of individual insureds prior to a specified age unless all coverage under the same franchise group is terminated and which are based on the level premium principle.

5. All other franchise policies as defined in s. 600.03 (34m) (d), Stats.

6. Commercial policies and other policies not falling within subpar. 1 to 5, inclusive, of this paragraph.

(b) During the period within which the renewability of the policy is guaranteed or the insurer's right to refuse renewal is limited, the minimum reserves for policies described in par. (a) 1 to 4 shall be an amount computed on the basis of 2-year preliminary term tabular mean reserves employing the following assumptions:

1. Mortality (Policies issued January 1, 1955 to December 31, 1967): American Men Ultimate Mortality Table or Commissioners 1941 Standard Ordinary Mortality Table or Commissioners 1958 Standard Ordinary Mortality Table. (See Table I at the end of this rule.)

2. Mortality (Policies issued after December 31, 1967): Commissioners 1958 Standard Ordinary Mortality Table. (See Table I at the end of this rule.)

3. Maximum Interest Rate: 3½% compounded annually.

4. Morbidity or Other Contingency:

a. Disability due to accident and sickness (Policies issued January 1, 1955 to December 31, 1967): The Conference Modification of Class III Disability Table for Calculation of Reserves on Non-Cancellable Accident and Health Insurance adopted by the National Association of Insurance Commissioners on June 11, 1941. Pamphlet reprints of this table are on file in the offices of the commissioner of insurance, secretary of state, and revisor of statutes. Pamphlet reprints of said Conference Modification of Class III Disability Table for Calculation of Reserves on Non-Cancellable Accident and Health Insurance are obtainable from the Health Insurance Association of America, 332 South Michigan Avenue, Chicago, Illinois 60604.

b. Disability due to accident and sickness (Policies issued after December 31, 1967): The 1964 Commissioners Disability Table adopted by the National Association of Insurance Commissioners on December 3, 1964. Copies of this table are on file in the offices of the commissioner of insurance, secretary of state, and revisor of statutes. Reprints of the 1964 Commissioners Disability Table and monetary values based on the table are available from the Health Insurance Association of America, 332 South Michigan Avenue, Chicago, Illinois 60604.

c. Hospital Expense Benefits—1956 Inter-Company Hospital Table. (See Tables II and III at the end of this rule.)

d. Surgical Expense Benefits—1956 Inter-Company Surgical Table. (See Tables IV and V at the end of this rule.)

e. Accident only, major medical expense, and other benefits not specified above—each company to establish reserves that place a sound value on the liabilities under such benefit.

(c) Mean reserves shall be diminished or offset by appropriate credit for the valuation net deferred premiums. In no event, however, shall the aggregate reserves for all policies issued on or after January 1, 1955, and valued on the mean reserve basis diminished by any credit for deferred

premiums, be less than the gross pro rata unearned premiums under such policies.

(d) Negative reserves on any benefit may be offset against positive reserves for other benefits in the same individual or family policy, but if all benefits of such policy collectively develop a negative reserve, credit shall not be taken for such amount.

(e) The minimum active life reserves for policies described in par. (a) 5 and 6 shall be the pro rata gross unearned premium reserve.

(f) An insurer may use any reasonable assumptions as to the interest rate, mortality rates, or the rates of morbidity or other contingency, and may introduce a rate of voluntary termination of policies provided the reserve on all policies to which such assumptions are applied is not less in the aggregate than the amount determined according to the standards specified in pars. (b), (c), (d), and (e). Also, subject to the same condition, the insurer may employ methods other than the methods stated above in determining a sound value of its liabilities under policies described in this subsection, including but not limited to the following:

1. The use of mid-terminal reserves in addition to either gross or net pro rata unearned premium reserves;

2. Optional use of either the level premium, the one-year preliminary term, or the two-year preliminary term method;

3. Prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses;

4. The use of approximations such as those involving age groupings, groupings of several years of issue, or average amounts of indemnity;

5. The computation of the reserve for one policy benefit as a percentage of, or by other relation to, the aggregate policy reserves, exclusive of the benefit or benefits so valued;

6. The use of a composite annual claim cost for all or any combination of the benefits included in the policies valued.

(g) For statement purposes the net reserve liability for active lives may be shown as:

1. The mean reserve with offsetting asset items for net unpaid and deferred premiums; or

2. The excess of the mean reserve over the amount of net unpaid and deferred premiums; or

3. It may, regardless of the underlying method of calculation, be divided between the gross pro rata unearned premium reserve and a balancing item for the "additional reserve."

(h) Each insurer issuing policies described by subparagraph 2 of paragraph (a) of this subsection shall maintain historical fund accounts for each group of similar policy forms on a basis reflecting reasonable estimates of premiums, losses, expenses, and reserves. Such estimates shall not be inconsistent with the corresponding items in the Accident and Health Exhibit, Schedule H, of the Annual Statement—Life and Accident and Health Companies, Insurance Department Form Form 22-41—

or with the corresponding items of the Underwriting and Investment Exhibit of the Annual Statement—Fire and Casualty Insurance Companies, Insurance Department Form 22-11. (s. Ins 7.01 (5) (a) and (c).)

(4) ACTIVE LIFE RESERVES, GROUP AND BLANKET POLICIES. Active life reserves are required for all in force policies issued subject to s. 600.03 (34m) (b) and (c), Stats.

(a) The minimum active life reserve for such policies shall be the pro rata gross unearned premium reserve.

(b) An additional active life reserve shall be established for converted policies which may be issued under a conversion option for terminated employes. The minimum reserve shall be the excess of the morbidity costs for such policies over morbidity costs assumed in the premiums to be payable by or on behalf of terminated employes.

(5) CLAIM LIABILITY RESERVES, INDIVIDUAL AND FRANCHISE. Claim liability reserves to represent the value of amounts not yet due on claims are required for all policies issued subject to s. Ins 6.75 (1) (c) or (2) (c), s. 600.03 (34m) (d), or 632.94, Stats.

(a) The minimum reserve for claim liabilities shall be computed employing the following assumptions:

1. Maximum Interest Rate: 3½% compounded annually.

2. Morbidity of Other Contingency:

a. Disability due to accident and sickness: The 1964 Commissioners Disability Table (see sub. (3) (b) 4.b), except that for unreported claims and resisted claims and claims with a duration of disablement of less than 2 years, reserves may be based on the individual insurer's experience or other assumptions designed to place a sound value on the liabilities. Reserves based on such experience or assumptions shall be verified by the development of each year's claims over a period of years, along lines of Schedule O, Life and Accident and Health Annual Statement, Insurance Department Form 22-41. (s. Ins. 7.01 (5) (c).)

b. All other benefits: The reserve shall be based on the individual company's experience or other assumptions designed to place a sound value on the liabilities. The results shall be verified by the development of each year's claims over a period of years.

(b)Insurers may employ suitable approximations and estimates, including but not limited to groupings and averages, in computing claim liability reserves.

(c) For policies with an elimination period, the duration of disablement should be considered as dating from the time that benefits would have begun to accrue had there been no elimination period.

(d) A new disability connected directly or indirectly with a previous disability which had a duration of at least one year and terminated within 6 months of the new disability should be considered a continuation of the previous disability.

(6) CLAIM LIABILITY RESERVES, GROUP AND BLANKET POLICIES. Claim liability reserves to represent the value of amounts not yet due on claims

are required for all policies issued subject to s. 600.03 (34m) (b) or (c), Stats.

(a) The minimum reserve for claim liabilities shall be computed employing the following assumptions:

1. Maximum Interest Rate: 3½% compounded annually.

2. Morbidity or Other Contingency:

a. Disability due to accident and sickness: The 1964 Commissioners Disability Table (see sub. (3) (b) 4.b.), except that for unreported claims and resisted claims and claims with a duration of disablement of less than 2 years, reserves may be based on the individual insurer's experience or other assumptions designed to place a sound value on the liabilities. Reserves based on such experience or assumptions shall be verified by the development of each year's claims over a period of years, along lines of Schedule O, Life and Accident and Health Annual Statement, Insurance Department Form 22-41. (s. Ins 7.01 (5) (c).)

b. All other benefits: The reserve shall be based on the individual company's experience or other assumptions designed to place a sound value on the liabilities. The results shall be verified by the development of each year's claims over a period of years.

(b) Insurers may employ suitable approximations and estimates, including but not limited to groupings and averages, in computing claim liability reserves.

(c) For policies with an elimination period, the duration of disablement should be considered as dating from the time that benefits would have begun to accrue had there been no elimination period.

(d) A new disability connected directly or indirectly with a previous disability which had a duration of at least one year and terminated within 6 months of the new disability should be considered a continuation of the previous disability.

(7) REVALUATION OF EXISTING ACTIVE LIFE RESERVES AND CLAIM LIABILITY RESERVES. An insurer may elect to establish and maintain active life reserves or claim liability reserves for policies issued prior to January 1, 1968 in accordance with the standards prescribed herein for policies issued after December, 31, 1967. In making such election, an insurer may elect to revalue all previous issues or, at its option, may revalue only certain blocks of issues as determined by issue date or plan of coverage. Claim reserves may be revalued independent of active life reserves. Such election shall be made by filling written notice with the commissioner, stating the effective date of the election and identifying the active life reserves or claim liability reserves or issues of policies to be revalued.

Note: Reserve Fund. This rule is based on the concept of the reserve as a fund which, together with future net premiums, will meet the benefit payments arising from the group of policies valued as they accrue in the future. It should be observed that the application of a formula for the calculation of such reserves to an individual policy does not produce a meaningful result since few policyholders will experience average morbidity. For the policyholder in impaired health, the necessary reserve, if it could be determined, would be very much greater than the average result for policyholders as a whole, and for a policyholder in good health such reserve would be less than the average.

Level Premium Principle. Policies written on the "level premium principle" are those where the premium has been designed to be level—or the same—for either the life of the insured or to the termination age in the policy such as age 60 or 65.

TABLE V

1956 INTER-COMPANY SURGICAL TABLE

EVALUATION SCHEDULE FOR SURGICAL BENEFITS
PER $100 SCHEDULE

Procedure	Weight	Amount Payable per $100 Maximum (Prorated if Maximum is other than $100)	Product
	Adult Male		
Benign tumors and cysts, superficial removal	.564		
Appendectomy	.712		
Cholecystectomy	.095		
Herniotomy, single	.391		
Herniotomy, bilateral	.101		
Hemorrhoidectomy, Int. or Ext.	.229		
Hemorrhoidectomy, Int. and Ext.	.154		
Prostatectomy, perineal or suprapubic	.059		
Nasal septum, submucous resection	.130		
Tonsillectomy and/or Adenoidectomy	.711		
	Adult Female		
Thyroidectomy, subtotal	.087		
Appendectomy	.429		
Cholecystectomy	.160		
Dilation and curettage	.330		
Uterine fixation	.096		
Panhysterectomy	.157		
Hysterectomy—abd.	.326		
Hysterectomy—vag.	.065		
Other uterine operations incl. oophorectomy etc.	.110		
Tonsillectomy and adenoidectomy	.304		

The weights are so determined that the sum of the products evaluates a schedule as a percentage of "standard", and are derived from the frequencies for the commoner operations. Apply the above factors (percentage of "standard") to the net annual claim costs for a $200 "standard" schedule shown in Table IV to obtain the adjusted net annual claim costs for a particular schedule ($200 basis). Where the particular schedule is for some amount other than $200, the factors should be adjusted accordingly (i.e. $250 schedule multiply by 1.25.)

History: Cr. Register, April, 1959, No. 40, eff. 5-1-59; am. (2) (a) and (b), Register, June, 1960, No. 54, eff. 7-1-60; am. (3) (a) and Table 1, Register, October, 1960, No. 58, eff. 11-1-60; r. and recr., Register, January, 1967, No. 133, eff. 2-1-67; emerg. am. to (1) to (6), eff. 6-22-76; am. (1), (2), (3) (intro.), (3) (a), 4 and 5, (3) (e), (4) (intro.), (4) (a), (5) and (6), Register, September, 1976, No. 249, eff. 10-1-76; am. (2), (3) and (5), Register, March, 1979, No. 279, eff. 4-1-79.

Ins 3.18 Total consideration for accident and sickness insurance policies. The total consideration charged for accident and sickness insurance policies must include policy and other fees. Such total consideration charged must be stated in the policy, and shall be subject to the reserve requirements of ch. 623, Stats., and s. Ins 3.17, and must be the basis for computing the amount to be refunded in the event of cancellation of the policy.

History: Cr. Register, May, 1959, No. 41, eff. 6-1-59; emerg. am. eff. 6-22-76; am. Register, September, 1976, No. 249, eff. 10-1-76.

Ins 3.19 Group accident and sickness insurance insuring debtors of a creditor. (1) This rule implements and interprets ss. 204.321 (1) (d) and 206.60 (2), 1973 Stats., with regard to issuance of a group policy of acci-

dent and sickness insurance issued to a creditor to insure debtors of a creditor.

(2) A group accident and sickness insurance policy may be issued to a creditor to insure debtors of the creditor if the class or classes of insured debtors meet the requirements of s. 206.60 (2) (a) and (c), Stats., [1973] and such a policy shall be subject to the requirements of such paragraphs in addition to other requirements applicable to group accident and sickness insurance policies.

History: Cr. Register, November, 1959, No. 47, eff. 12-1-59; am. Register, September, 1963, No. 93, eff. 10-1-63; r. (3), Register, February, 1973, No. 206, eff. 3-1-73; emerg. am. (1) and (2), eff. 6-22-76; am. (1) and (2), Register, September, 1976, No. 249, eff. 10-1-76.

Ins 3.20 Substandard risk automobile physical damage insurance for financed vehicles. (1) PURPOSE. In accordance with s. 204.49 (4), Stats., this rule is to accomplish the purpose and enforce the provisions of ch. 625, Stats., in relation to automobile physical damage insurance for substandard risks.

(2) SCOPE. This rule applies to any automobile physical damage insurance policy procured or delivered by a finance company.

(3) DEFINITIONS. (a) *Substandard risk* means an applicant for insurance who presents a greater exposure to loss than that contemplated by commonly used rate classifications as evidenced by one or more of the following conditions:

1. Record of traffic accidents.

2. Record of traffic law violations.

3. Undesirable occupational circumstances.

4. Undesirable moral characteristics.

(b) *Substandard risk rate* means a rate or premium charge that reflects the greater than normal exposure to loss which is assumed by an insurer writing insurance for a substandard risk.

(4) RATES FOR SUBSTANDARD RISKS. (a) Any increased rate charged for substandard risks shall not be excessive, inadequate, or unfairly discriminatory.

(b) It shall be unfairly discriminatory to charge a rate or premium that does not reasonably measure the variation between risks and each risk's exposure to loss.

(c) Classification rates filed for substandard risks may not exceed 150% of the rate level generally in use for normal risks unless the filing also provides for the modification of classification rates in accordance with a schedule which establishes standards for measuring variation in hazards or expense provisions or both.

(5) INSURANCE COVERAGE. (a) The automobile physical damage insurance afforded shall be substantially that customarily in use for normal business.

(b) The applicant shall not be required to purchase more coverage than is customarily necessary to protect the interests of the mortgagee.

APPENDIX I

INFORMATION SHEET ON CANCER INSURANCE

Cancer Insurance is Not a Substitute for Comprehensive Coverage.

Should You Buy Cancer Insurance?

Caution: Limitations On Cancer Insurance.

Prepared by the National Association of Insurance Commissioners

CANCER INSURANCE . . .

Cancer insurance is one of the fastest growing and most controversial forms of health insurance. It provides benefits only if you get cancer. No policy will cover cancer diagnosed before you applied for the policy. Examples of other specified disease policies are heart attack or stroke policies. The information in this booklet applies to cancer insurance, but could very well apply to other specified disease policies.

CANCER INSURANCE IS NOT A SUBSTITUTE FOR COMPREHENSIVE COVERAGE . . .

Cancer treatment accounts for less than 6% of U.S. health expenses. In fact, no single disease accounts for more than a small proportion of the American public's health care bill. This is why it is essential to have insurance coverage for all conditions, not just cancer.

If you and your family are not protected against catastrophic medical costs, you should consider a major medical policy. These policies pay a large percentage of your covered costs after a deductible is paid either by you or your basic insurance. They often have very high maximums, such as $100,000 to $1,000,000. Major medical policies will cover you for any accident or sickness, including cancer. They cost more than cancer policies, but they are generally considered a better buy.

SHOULD YOU BUY CANCER INSURANCE? . . . MANY PEOPLE DON'T NEED IT

If you are considering cancer insurance, ask yourself three questions: Is my current coverage adequate for these costs? How much will the treatment cost if I do get cancer? How likely am I to contract the disease? If you have Medicare and want more insurance, a comprehensive Medicare supplement policy is what you need.

Low income people who are Medicaid recipients don't need any more insurance. If you think you might qualify, contact your local social service agency.

Duplicate Coverage is Expensive and Unnecessary. Buy basic coverage first. Make sure any cancer policy will meet needs not met by your basic insurance. You cannot assume that double coverage will result in double benefits. Many cancer policies advertise that they will pay benefits no matter what your other insurance pays. However, your basic policy may contain a Coordination of Benefits clause. That means it will not pay duplicate benefits. To find out if you can get benefits from both policies, check your regular insurance as well as the cancer policy.

Some Cancer Expenses May Not Be Covered Even by a Cancer Policy. Medical costs of cancer treatment vary. On the average, hospitalization accounts for 78% of such costs and physician services make up 13%. The remainder goes for other professional services, drugs and nursing home care. For 1978, the average hospital cost for cancer treatment was $4,228. Cancer patients often face large nonmedical expenses which are not usually covered by cancer insurance. Examples are home care, transportation and rehabilitation costs.

Don't be Misled by Emotions. While one in four Americans will get cancer over a lifetime, three in four will not. In any one year, only one American in 285 will get cancer. The odds are against a Policyholder receiving any benefits.

CAUTION: LIMITATIONS OF CANCER INSURANCE . . .

Cancer policies sold today vary widely in cost and coverage. Contact different companies and agents, and compare the policies before you buy. Here are some common limitations:

Some policies pay only for hospital care. Today cancer care treatment, including radiation, chemotherapy and some surgery, is often given on an outpatient basis. Because the average stay in the hospital for a cancer patient is only 16 days, a policy which pays only when you are hospitalized has limited value.

Many policies promise to increase benefits after a patient has been in the hospital for 90 consecutive days. However, 99% of all cancer patients spend less than 60 days in the hospital. Large dollar amounts for extended benefits have very little value for most patients.

Many cancer insurance policies have fixed dollar limits. For example, a policy might pay only up to $1,500 for surgery costs or $1,000 for radiation therapy, or it may have fixed payments such as $50 or $100 for each day in the hospital. Others limit total benefits to a fixed amount such as $5,000 or $10,000.

No policy will cover cancer diagnosed before you applied for the policy. Some policies will deny coverage if you are later found to have had cancer at the time of purchase, even if you did not know it.

Most cancer insurance does not cover cancer-related illnesses. Cancer or its treatment may lead to other physical problems, such as infection, diabetes or pneumonia.

Many policies contain time limits. Some policies require waiting periods of 30 days or even several months before you are covered. Others stop paying benefits after a fixed period of two or three years.

FOR ADDITIONAL HELP . . .

If you are considering a cancer policy, the company or agent should answer your questions. If you do not get the information you want, discuss the matter with your State Insurance Department.

Ins 3.48 Preferred provider plans. (1) SCOPE. This section applies to all preferred provider plans as defined in s. 628.36 (2a) (a) 1., Stats.

(2) EXCESSIVE DISTANCES. (a) Except as provided in pars. (b) and (c), preferrd provider plans shall offer coverage to a person only if preferred

providers of primary care services and emergency services are available within 30 minutes' travel time of the person's place of residence.

(b) A preferred provider plan may offer coverage on a group basis to an employer for its employes or to an employe organization without taking into account the places of residence of the employes, if preferred providers of primary care services and emergency services are available either within the county or within 30 minutes' travel time of the employment location.

(c) A preferred provider plan may provide coverage to a person without taking into account the person's place of residence or employment if the person is informed in writing of the services covered and the location of all preferred providers and makes a written request for coverage.

(3) CONTINUITY OF PATIENT CARE. (a) Subject to pars. (b), (c), (d) and (e), a preferred provider plan which is offered on a group basis to an employer for its employes or to an employe organization shall extend enrollment periods for group members and their families who wish to be enrolled in the plan, but who are in a course of treatment with a provider not selected by the plan and wish to continue that course of treatment. Enrollment standards for those who request an extended enrollment period shall be no more restrictive than they are for those who enroll during the normal enrollment period.

(b) A preferred provider plan may require a group member to request an extended enrollment period during the normal enrollment period specified by the plan and to indicate the nature and the expected duration of the course of treatment.

(c) A preferred provider plan is not required to extend enrollment opportunities to a dependent of a group member unless the group member and any other dependents also receive an extension.

(d) A preferred provider plan may limit the extension of the enrollment period for a group member and dependents to 90 days after the effective date of the contract.

(e) A preferred provider plan shall receive no premiums and bear no responsibility for coverage of group members and their dependents until they are enrolled.

(f) When a person changes from one plan to another, the responsibilities of the prior and succeeding insurers outlined in s. Ins 6.51 (6), (7) and (8) shall apply.

(4) SUBSTANTIALLY EQUIVALENT BENEFITS DEFINED. (a) For purposes of s. 628.36 (2a) (d), Stats., plans will be considered to provide substantially equivalent benefits if they offer comparable coverage for the following services: hospital room and board, other inpatient hospital services, surgery, home and office physician services, inhospital physician care, x-ray and laboratory services.

(b) Notwithstanding par. (a), plans providing substantially equivalent benefits may differ as to premium, deductible, coinsurance, benefit maximum provisons and limitations on choice of providers.

(c) Plans providing substantially equivalent benefits may differ in their coverage of services other than those listed in par. (a).

(5) ADEQUATE NOTICE. (a) Preferred provider plans shall provide to policyholders information on the plan, including information on the services covered; a definition of emergency services if emergency services are covered differently than other services; the specific location of providers for each type of service; the cost of the plan; enrollment procedures; limitations on benefits, including limitations or requirements imposed by an institutional provider because of its affiliation with a religious organization; and restrictions on choice of providers. This information shall be provided to employers at least 30 days before the first day of each enrollment period. The preferred provider plans shall ensure that employers make this information available to all prospective certificate holders in time for them to make an informed choice among available plans. If a preferred provider plan is offered on an individual basis, the information shall be given at the time of application.

(b) The information provided shall be legible, complete, understandable, presented in a meaningful sequence, contain a single section listing exclusions and limitations and define words and expressions which are not commonly understood or whose commonly understood meaning is not intended.

(c) The information provided shall meet the standards for an invitation to apply set forth in s. Ins 3.27.

(6) NONPREFERRED PROVIDERS. A preferred provider plan may require that, if a person enrolled in the plan receives health care services from providers not selected by the plan, the person shall pay, in addition to any applicable premium and deductible, an additional portion of the total payment to be made to the providers. The sum of these additional amounts may not be more than $2,500 per year for individual coverage nor more than $5,000 per year for family coverage.

History: Cr. Register, June, 1984, No. 342, eff. 7-1-84; r. (7) under s. 13.93 (2m) (b) 16, Stats., Register, December, 1984, No. 348.

Ins 3.49 Wisconsin automobile insurance plan. (1) PURPOSE. This section interprets s. 619.01 (6), Stats., to continue a plan to make automobile insurance available to those who are unable to obtain it in the voluntary market by providing for the equitable distribution of applicants among insurers and outlines access and grievance procedures for such a plan.

(2) DEFINITIONS. In this section:

(a) "Committee" means the governing committee of the Wisconsin Automobile Insurance Plan which is the group of companies administering the Plan.

(b) "Plan" means the Wisconsin Automobile Insurance Plan, an unincorporated facility established by s. 204.51 [Stats., (1967)] and continued under s. 619.01 (6), Stats.

(3) FILING AND ACCESS. The committee shall submit revisions to its rules, rates and forms for the Plan to the commissioner. Prior approval by the commissioner of the documents is required before they may become effective. The documents shall provide: